State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One
Full legal name	John Dempsey Hospital
Doing Business As	
Name of Parent Corporation	University of Connecticut Health Center University of Connecticut State of Connecticut
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	263 Farmington Avenue Farmington, CT 06030-3802
Applicant type (e.g., profit/non-profit)	State Agency
Contact person, including title or position	Paula McManus Associate Vice President
Contact person's street mailing address	263 Farmington Avenue Farmington, CT 06030-3802
Contact person's phone #, fax # and e-mail address	Phone: 860-679-3180 Fax: 860-679-1130 Email: mcmanus@nso.uchc.edu

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

ICU expansion

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc)	☐ Replacement	☐ Additional (F, S, Fnc)
☒ Expansion (F, S, Fnc)	☐ Relocation	☐ Service Termination
☒ Bed Addition`	☐ Bed Reduction	☐ Change in Ownership/Control

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☒ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New	☐ Replacement	☐ Major Medical
☐ Imaging	☐ Linear Accelerator	

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):

263 Farmington Avenue
Farmington, CT 06030

d. List all the municipalities this project is intended to serve:

Avon, Burlington, Bloomfield, Canton, East Hartford, Farmington, Granby, Hartford, New Britain, Newington, Simsbury, West Hartford, Barkhamsted, Berlin, Bristol, Cromwell, East Granby, East Windsor, Glastonbury, Hartland, Harwinton, Litchfield, Manchester, New Hartford, Plainville, Plymouth, Rocky Hill, South Windsor, Southington, Torrington, Vernon, Wethersfield, Winchester, and Windsor

e. Estimated starting date for the project: June 2006

f. Type of project: **10** (Fill in the appropriate number(s) from page 7 of this form).

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
Med/Surg/ICU	204	204	7	211

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $1,700,000

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$1,600,000
Medical Equipment (Purchase)	200,000
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$1,800,000**

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☒ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: John Dempsey Hospital

Project Title: ICU Expansion

I, Steven L. Strongwater, M.D , Hospital Director
(Name) (Position – CEO or CFO)

of John Dempsey Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that John Dempsey Hospital complies with the appropriate and
(Facility Name)
applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 8/12/05
Date

Subscribed and sworn to before me on 8/12/05

Notary Public/~~Commissioner of Superior Court~~

My commission expires:

KRYSTYNA LIPINSKI
NOTARY PUBLIC
MY COMMISSION EXPIRES MAY 31, 2009

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Project Description

Applicant: John Dempsey Hospital
Project Title: ICU expansion

John Dempsey Hospital proposes to expand its ICU, adding 7 beds, thereby increasing the number of ICU beds from 15 to 22 and increasing the licensed bed capacity of the hospital from 204 to 211 (excluding bassinets). John Dempsey Hospital currently has all of its licensed beds in service and staffed. In recent months mid-week occupancy often exceeded 85% and has been as high as 91%. Individual units have been fully occupied on many days. The ICU occupancy has some variability but during the past winter months has experienced days at or close to 100%.

The allocation of John Dempsey Hospital's 204 beds is somewhat unusual. A very high percentage of the beds are allocated and used for specialized purposes e.g. Psychiatry (34 beds), NICU (40 beds), locked unit for Department of Correction (12 beds), Maternity (20 beds). Only 98 beds can be considered general med/surg/ICU beds. Those beds are organized on units including Surgery, Medicine, Oncology, Cardiac Step Down, and ICU. It would be imprudent to take beds out of service on any of the specialized units and reallocate them to the ICU, since the occupancy trends on those units indicate that the number of beds currently allocated is needed to accommodate the need.

Additional beds in the ICU will accommodate patients who require an intensive level of care in accordance with protocols. Patient safety as well as the effective use of scarce nursing resources is a primary goal of the John Dempsey Hospital. Tactics to achieve those goals include the ability to accommodate patients who need intensive care in the ICU where they can be attended by the hospitalist/intensivist physicians dedicated to the ICU and the dedicated ICU nursing staff. Further, patient safety is impacted by the ability to transfer patients in a timely manner from the Emergency Department to an inpatient unit appropriate to meet the needs of the patient. The John Dempsey Hospital Emergency Department visits continue to grow year over year. Bed availability is a growing reason for delays in the transfer of patients to a unit where an appropriate level of care can be provided.

Demographic and market data lead to projections of increasing admissions and ICU days. The John Dempsey Hospital Service Area, particularly the Farmington Valley, is growing in population. That in addition to a continuing shift in the age mix to the more senior brackets as well as the technology advancemans contributes to increasing use rate projections.

John Dempsey Hospital's Strategic Plan is integrated with that of the UConn Health Center (UCHC) of which it is an integral part. John Dempsey Hospital is committed to establishing and maintaining a clinical venue for the clinical pursuits of the faculty of the School of Medicine, as well as a state of the art care delivery system for the training of students and residents and the conduct of clinical trials.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 26, 2005

Paula McManus
Associate Vice President
John Dempsey Hospital
263 Farmington Ave.
Farmington, CT 06030-3802

RE: Certificate of Need Application Forms; Docket Number: 05-30572-CON
John Dempsey Hospital
Intensive Care Unit Seven Bed Expansion Project

Dear Ms. McManus:

Enclosed are the application forms, in paper copy and an electronic copy on CD, for John Dempsey Hospital's Certificate of Need ("CON") proposal for the Intensive Care Unit Seven Bed Expansion Project with an associated capital expenditure of $1,800,000. According to the parameters stated in Sections 19a-638 and 19a-639 of the Connecticut General Statutes the CON application may be filed between October 14, 2005, and December 13, 2005.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The OHCA analyst assigned to the CON application is Jack A. Huber. Please feel free to contact him at (860) 418-7034, if you have any questions.

Sincerely,

Kimberly Martone

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 14, 2005, and may be submitted no later than December 13, 2005. The Analyst assigned to your application is Jack A. Huber and he may be reached at the Office of Health Care Access at (860) 418-7034.

Docket Number:	05-30572-CON
Applicant Name:	John Dempsey Hospital
Contact Person:	Paula McManus
Contact Title:	Associate Vice President
Contact Address:	John Dempsey Hospital 263 Farmington Ave. Farmington, CT 06030 3802
Project Location:	Farmington
Project Name:	Intensive Care Unit Seven Bed Expansion
Proposal Type:	Sections 19a-638 and 19a-639, C.G.S.
Estimated Total Capital Expenditure: *(Note: Does not include Capitalized Financing Costs)*	$1,800,000

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, Change of Ownership, Service Termination. **No Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure/Cost excluding capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	$_____.00
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No If "No" is checked, please provide a brief explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns;
   b) The units of service (i.e. patient days, discharges, etc.) for the past three fiscal years by service area town;
   c) The population to be served, including the number of individuals to receive the service. Include demographic information, as appropriate;
   d) Scheduling backlogs in service area;
   e) Travel distance from the Hospital to service area towns; and
   f) Hours of operation of the existing service.

ii) Identify the existing providers of the proposed service in your primary service area (PSA). Provide the information as formatted in the table found at the top of the next page concerning the existing providers.

Description of Service[1]	Provider Name and Location	Capacity[2]	Current Utilization[3]

[1] **Level of care.**
[2] **Number of beds available to serve patients.**
[3] **Reportable in bed days, admissions, discharges and/or average percent occupancy.**

iii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iv) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? If you checked other than "None of the above", please provide a brief explanation of each identified barrier to be remedied by the proposal.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

C. Provide copies of any of the following plans, studies or reports that relate to your proposal. Provide a brief explanation as to how each document relates to the proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐None: If ***"none"*** was checked, please provide an explanation as to why there were no reports, studies or market share analysis produced that related to the proposal:

_____

_____

_____

_____

5. Quality Measures

A. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology
☐ National Committee for Quality Assurance
☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers
☐ American College of Obstetricians & Gynecologists
☐ American College of Surgeons
☐ Report of the Inter-Society Council for Radiation Oncology
☐ American College of Radiology
☐ Substance Abuse and Mental Health Service Administration
☐ Other: Please specify- _____

B. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

C. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

D. Provide copies of the most recent inspection certificates, inspection reports and plans of correction for your facility as they pertain to the following organizations:

☐ DPH
☐ JCAHO
☐ Fire Marshall Report
☐ Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC
☐ AAAASF
☐ Other: Please specify- _____

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

E. Provide copies of any Quarterly Action Reports, Consent Decrees or Statement of Charges against the Hospital, its physicians and any professional staff related to the proposal, for the past five (5) years.

F. Provide a copy of any plan of action which has been formulated to address the above action against the Hospital, its physicians working at the Hospital and any staff related to the proposal.

G. Provide a copy of the latest related excerpts from the Quality Assurance plan and the most recent edition of the annual evaluation report regarding the facility Quality Assurance plan.

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other- Please specify: _____

7. Miscellaneous

A. Will this proposal result in new or modified teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide a brief explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide a brief explanation.

C. Please provide a copy of the State of Connecticut Department of Public Health license currently held.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Does the Applicant have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. As the hospital has filed its most recently completed fiscal year audited financial statements, the Hospital may reference that filing for this proposal.

ii) Please provide the total current assets balance as of the date of submission of this application.

iii) Please provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Scanning Equipment (Purchase)	$
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Scanning Equipment (Lease (FMV))	$
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Total Capital Project Cost	**$**
Capitalized Financing Costs (For Informational Purposes Only)	
Total Capital Expenditure with Cap. Fin. Costs (For Informational Purposes Only)	$

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Explain how the proposed new construction or renovations will affect the delivery of patient care.

D. Provide the expected commencement date of the proposed service expansion.

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or

☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format as presented in the table found at the top of the next page.

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

B. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Please refer to Attachment F enclosed.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Describe how this proposal is cost effective.

vi) Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

12.

13. B(i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: Description	FY Actual Results	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON	FY Projected W/out CON	FY Projected Incremental	FY Projected With CON
NET PATIENT REVENUE										
Non-Government				$0			$0			$0
Medicare				$0			$0			$0
Medicaid and Other Medical Assistance				$0			$0			$0
Other Government				$0			$0			$0
Total Net Patient Patient Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Operating Revenue										
Revenue from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OPERATING EXPENSES										
Salaries and Fringe Benefits				$0			$0			$0
Professional / Contracted Services				$0			$0			$0
Supplies and Drugs				$0			$0			$0
Bad Debts				$0			$0			$0
Other Operating Expense				$0			$0			$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Depreciation/Amortization				$0			$0			$0
Interest Expense				$0			$0			$0
Lease Expense				$0			$0			$0
Total Operating Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Income (Loss) from Operations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Operating Income				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes										
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTEs				0			0			0

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.